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ALTA BATES HOSPITAL
3001 COLBY STREET AT ASHBY ■ BERKELEY ■ CALIFORNIA 94705
A NON-PROFIT HEALTH CENTER
■ ■ (415) 845-7110 ■

May 4, 1981

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Dear Friend:

On March 9, 1981 a group calling themselves "Concerned Citizens for People's Health (CCPH)," distributed widely a report to many organizations, individuals and agencies in the Bay Area. Its authors are people who live in our adjacent neighborhoods and are opposed to Alta Bates replacing our 1928 Building and the valuable outpatient programs it contains as well as our high-risk obstetrical bed expansion.

In April we responded to those inaccurate and very misleading sections of the report dealing with our high-risk obstetrical program, cesarean section rate, costs of services, and occupancy of neighboring hospitals. Attached is our response to other sections of that same report dealing primarily with their false charges of unnecessary duplication of services and our relationship with Herrick Hospital.

We are making this effort to correct their misinformation so that as important opinion and decision makers, you will have the facts in answering these questions and forming opinions about Alta Bates Hospital and the services we provide.

If you have questions or desire additional information, please call Mr. David O'Neill, Executive Vice President of Alta Bates Hospital, 845-7110, Ext. 2077.

Thank you in advance for taking time to read this response.

Sincerely,

Robt G. Eaneman

ROBERT G. EANEMAN, President
Board of Trustees

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May 5, 1981

TO: Members of the Board of Adjustments
City of Berkeley

FROM: Alta Bates Hospital

SUBJECT: Relationship between Alta Bates and Herrick Hospitals

The widely publicized March 9th report from the Concerned Citizens for People's Health (CCPH) has raised a number of questions regarding the relationship between the services at Alta Bates and Herrick Hospitals. On the following pages, we offer information that should clarify these questions.

More specifically, the enclosed information documents that

- Alta Bates has not made or broken any commitment with Herrick Hospital regarding the development of an Emergency Department or other services.
- Alta Bates and Herrick have an agreement to jointly discuss program and service development and mutually recognize that factors governing necessary and unnecessary duplication are ever changing due to the nature of medical science and the practice of medicine.
- Alta Bates' medical/surgical services have not adversely impacted on Herrick.
- Alta Bates expanded its Emergency Room to a Basic Emergency Department Service in response to changing utilization patterns and acute hospital needs. Both Hospitals' emergency services are well utilized and it is unlikely that any emergency facility would be able to serve the combined 50,000 emergency visits that both facilities now serve.
- Alta Bates' proposed surgical suite is needed to meet its present service demand and to avoid scheduling surgeries late into the evening.
- Alta Bates' stroke rehabilitation program at Albany was developed with community input and in response to community need; it does not adversely impact Herrick.
- Alta Bates' dialysis program, cardiac catheterization laboratory and radiation decontamination service are not unnecessary duplications of Herrick's services.

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- Since Alta Bates opened the first burn center and the first hospital-based alcohol rehabilitation program in the East Bay, these services were not unnecessarily duplication by Alta Bates.

- Alta Bates Hospital has justified its needs for 22 High-Risk Obstetrical beds on its own merit. Herrick should justify its request for transfer of 30 SNF beds to Med/Surg use on its own merit. The two should not be interlinked.

1. PAST "COMMITMENTS" BETWEEN ALTA BATES AND HERRICK

The CCPH report characterized Herrick Hospital as particularly vulnerable to competition from Alta Bates, "...because of its proximity and high percentage of Medi-Cal patients," (CCPH, pg. 16). The report also mentions a number of agreements allegedly broken by Alta Bates. However, it should be noted that:

A. NONE OF THE SERVICES MENTIONED HAS EVER BEEN SUBJECT TO WRITTEN OR ORAL AGREEMENT BETWEEN ALTA BATES AND HERRICK.

On pages 16 and 17 the CCPH report alleges that Alta Bates made and broke agreements with Herrick regarding

- Emergency services
- Radiation Decontamination
- Cardiac Catheterization
- Rehabilitation
- Chronic Dialysis

Alta Bates has not made either written or oral agreements with Herrick in any of these areas.

B. ALTA BATES AND HERRICK HAVE A WRITTEN AGREEMENT TO TRY TO AVOID UNNECESSARY DUPLICATION OF SERVICES THROUGH THE PRINCIPLE OF PROGRAM DEVELOPMENT REVIEW.

In 1973 the two hopsitals formed a Joint Planning Board Committee comprised of Trustees and Chief Executive Officers to review each other's future program development plans and to pursue other issues of mutual concern. They agreed to try to avoid unnecessary duplication of specialized services and adopted a written agreement committing themselves to the process of future program review.

At the time this committee was formed, Herrick provided specialized services in Emergency, Psychiatry and Rehabilitation. Because of the changing nature of medical science and the practice of medicine, both hospitals recognized that a service which at one time was considered specialized may later become a standard or basic part of any major urban acute care hospital's services. Certainly this happened with Emergency Room Services, which now are a basic element of most urban acute care hospitals. In addition, Herrick developed services in the last seven years that are duplicative, but not unnecessarily, of services that already existed at Alta Bates:

- Pulmonary Function Laboratory
- Vascular Laboratory
- Gastroenterology Laboratory Program
- CT-Scanner
- Home Care
- Hospice (under consideration at Herrick)
- Ultrasound Service

C. IN SHORT, THE TWO HOSPITALS HAVE AN AGREEMENT TO MUTUALLY REVIEW SERVICES DURING PLANNING TO AVOID DUPLICATION, BUT NOT TO LIMIT SPECIFIC PROGRAMS WHICH MAY BE JUSTIFIABLY DUPLICATED OVER TIME AS SERVICE DEMANDS CHANGE.

2. MEDICAL/SURGICAL HOSPITAL UTILIZATION AND ECONOMIC IMPACT

The CCPH report (page 17, #6) and testimony at the Board of Adjustments meeting claimed that Alta Bates' program development was adversely affecting Herrick. The report further alleged that Alta Bates' charges are too high (pages 10, 11, 13). We offer the following facts:

A. OCCUPANCY OF MEDICAL/SURGICAL SERVICES AT BOTH HOSPITALS IS ABOUT 80%.

The most recent facility annual reports showed Alta Bates' medical/surgical occupancy at 80% and Herrick's at 75%. Herrick officials reported at the March 30 Board of Adjustments meeting that average occupancy at their facility was currently 78%. Herrick remains a successful, well-utilized facility.

B. THE COST OF SERVICES AT HERRICK IS HIGHER THAN AT ALTA BATES.

Herrick's current average charges are 6.4% higher than Alta Bates' for room and services, and an average of 15% higher for common ancillary charges.

C. HERRICK'S NET INCOME WAS OVER TWICE AS HIGH AS ALTA BATES' DURING 1978.

The most recent California Health Facilities Commission (CHFC) report (1978) revealed that Herrick's net income was $2,208,996 (5.7% of gross revenue), while Alta Bates' net income was $883,665 (2.2% of gross revenue).

3. EMERGENCY SERVICES

Today both Alta Bates and Herrick operate "Basic" level Emergency Services according to State licensing definitions. Herrick has been the designated facility responsible for the coordination of emergency services within the Berkeley-Albany zone of the County Emergency System. Alta Bates supported this designation at the time it was granted in 1976. Both Herrick and Alta Bates have well-utilized emergency services, each averaging over 25,000 visits a year. It is probable that no one facility in Berkeley has the capacity to handle the two hospitals' combined volume of 50,000 emergency visits per year.

A. ALTA BATES UPGRADED ITS EMERGENCY SERVICE IN 1973 IN RESPONSE TO CHANGING UTILIZATION PATTERNS.

A number of factors influenced Alta Bates' decision in 1973 to upgrade its "Standby" Emergency Room to a full "Basic" Emergency Room with 24 hour on-duty physician coverage:

- Changes in Medi-Cal reimbursement in the 1970's forced increasing numbers of low income patients to seek primary health care in Emergency Departments rather than in physicians' offices. Alta Bates was faced with thousands of patients coming to the hospital for emergency care without an organized Emergency Department.

- Herrick's Emergency Department was well-utilized and frequently overcrowded at this time. It did not appear to have sufficient capacity to absorb the increasing demand for services.

- A Basic ER was needed to support vital, specialized inpatient programs which required 24-hour in-house physician coverage.

- A Basic ER was needed as a resource for the growing number of physicians and patients who were already oriented to Alta Bates for services.

B. WIDESPREAD RECOGNITION OF THE INCREASING RELIANCE OF PATIENTS ON ER'S LED MANY HOSPITALS IN URBAN AREAS TO CREATE BASIC ER'S.

Today, other hospitals nearby which operate Basic ER's include:

- Brookside
- Merritt
- Providence
- Children's
- John Muir
- Mt. Diablo
- Highland

In fact, Peralta Hospital is the only large acute care hospital in the area surrounding Alta Bates which does not have a Basic ER.

4. SURGERY

The CCPH report states (page 17) that Herrick's new operating room capacity is under-utilized, and notes that Herrick recently applied to the State to increase its medical/surgical bed capacity. The report alleges (page 18) that Alta Bates was trying to bypass the governmental review process by building only one surgical suite, instead of the two originally planned.

A. HERRICK HAS OVERBUILT ITS SURGICAL CAPACITY.

Herrick recently completed rebuilding its surgical suite and overbuilt its capacity in terms of present service demand and a reasonable expectation of service growth. There is no evidence that Herrick turns away surgical cases because of a shortage of medical/surgical beds. Rather, the requested additional medical/surgical beds appear to be needed to match the newly expanded surgical capacity.

B. ALTA BATES NEEDS ONE MORE SURGICAL SUITE TO ACCOMMODATE PRESENT SERVICE DEMAND.

The surgical suites at Alta Bates, with an average utilization of 75 to 80%, are the second most highly utilized surgical facilities in the Bay Area. Alta Bates needs an additional surgical room, not to accommodate new cases, but rather to facilitate scheduling of existing cases in a manner more conducive to quality patient care. Surgeries are frequently scheduled late in the day due to insufficient capacity.

Although Alta Bates originally explored the feasibility of adding two suites to the current surgical area, architectural studies indicated that two rooms with their required support space could not be accommodated in the available space. For this reason, we changed our plans to develop one large surgical suite for complex surgical cases which require extensive back-up equipment.

C. THE SURGICAL SUITE PROJECT FALLS BELOW THE HSA REVIEW THRESHOLD.

The addition of one more surgical suite will cost less than the $222,300 threshold calling for state and local health planning agency review. We believe that the addition of one room will satisfactorily correct current overcrowding in our surgical facility.

5. ALTA BATES AT ALBANY

The CCPH report questioned the appropriateness of using Alta Bates at Albany for stroke and head injury patients (page 17) and suggested that it be used as a site for the hospital's inpatient alcohol rehabilitation program currently housed at the Berkely site.

A. ALTHOUGH ALTA BATES PREVIOUSLY CONSIDERED AN ALCOHOL PROGRAM AT THE ALBANY SITE, THE CONCEPT WAS PROTESTED BY ALBANY CITY OFFICIALS AND COMMUNITY.

In 1978 Alta Bates explored the feasibility of acquiring Albany Hospital and relocating our acute alcohol rehabilitation service there. Discussions were held with the Albany City Manager, the City Council and other community representatives. All made it quite clear that they did not want to see an inpatient alcohol service at the Albany site. Under previous management, the Albany facility had been used partially as an alcohol treatment unit, which was apparently operated with questionable quality. As a result, the community was quite adamant about not wanting another service of this nature established there. At the conclusion of these discussions, Alta Bates decided it would not be appropriate to ignore community feelings and temporarily tabled the effort to acquire Albany Hospital in the absence of a definable need.

B. IN RE-EVALUATING USE OF THE ALBANY FACILITY, ALTA BATES SOUGHT COMMUNITY INPUT AND EXPLORED MANY ALTERNATIVES FOR USING THE ALBANY SITE. THE NEED FOR A STROKE AND HEAD INJURY REHABILITATION SERVICE WAS DEMONSTRATED.

In a 1979 analysis Alta Bates thoroughly assessed local needs in determining the most appropriate service to offer at the Albany site. Several programs were considered before we determined that there was a continuing need for general medical care, as well as a special need for a stroke and head injury rehabilitation service. We received input from local physicians, members of the Albany City Council and other local citizen groups who concurred that these needs existed, since close to 25% of Albany's residents are over the age of 65. At this time, representatives of the Albany community reaffirmed their opposition to locating the alcohol service at Albany and requested that we continue the outpatient x-ray, lab and Meals-on-Wheels services at the Albany site.

Studies showed that numerous patients at Alta Bates and elsewhere in the East Bay were regularly referred to stroke rehabilitation facilities in Marin, San Francisco and Santa Clara, or were forced to remain in acute care facilities not equipped to deal with their unique rehabilitation needs. An analysis was made on patients discharged from Alta Bates at Berkeley between July 1977 and July 1978 with diagnoses of stroke and intracranial injury. The conclusion projected an average of 10 to 22 patients would be transferred from the Berkeley site to a stroke and head injury service at Alta Bates at Albany.

C. STUDIES SHOWED THAT SUCH A PROGRAM WOULD NOT ADVERSELY IMPACT HERRICK. SINCE THE ACQUISITION OF ALBANY BY ALTA BATES, THE CENSUS OF HERRICK'S REHABILITATION PROGRAM HAS HELD STEADY.

Our analysis also indicated at that time that a stroke and head injury rehabilitation program would not adversely impact Herrick Hospital for the following reasons:

- Stroke patients at Alta Bates, as well as at most other East Bay facilities, were being cared for at their own acute facilities and were not being transferred to Herrick Hospital.

- The program at Albany could easily be distinguished from the broader scope Rehabilitation Center at Herrick, with its specialized focus on quadraplegics and paraplegics and other spinal cord injury patients. Therefore, we did not anticipate Herrick would experience a drop in rehabilitation patients because of the 10 to 22 patients referred to Alta Bates at Albany from the Berkeley site.

- Herrick officials stated at the March 30 Board of Adjustments meeting that their average census is 12 to 14 patients in their rehabilitation unit, which shows little change from their average occupancy as reported in 1977, 1978 and 1979 Annual Reports.

D. ALTA BATES' REHABILITATION PROGRAM AT ALBANY IS GROWING STEADILY

Since Alta Bates opened its rehabilitation program at the Albany site, the average stroke/head injury patient census has grown to 21 with a current waiting list of three to four patients, the majority of whom have been referred from our Berkeley facility. With the addition of more specialized staff, we expect the occupancy of Alta Bates at Albany to reach 80% or higher. There is no reason to assume these patients would otherwise have been transferred to Herrick for rehabilitation services, since this is not consistent with established physician referral practices.

6. OTHER ALLEGED DUPLICATION OF SERVICES WITH HERRICK HOSPITAL.

While Alta Bates and Herrick both maintain programs in chronic dialysis, cardiac catheterization and radiation decontamination, these services are not unnecessarily duplicated and are, in fact, well-utilized in a cost-effective manner.

A. DIALYSIS SERVICES (P. 17 OF CCPH REPORT).

Herrick opened its dialysis unit about two years before Alta Bates did in 1973. Many dialysis stations have opened since then in the surrounding community, all with regulatory approval.

- Four facilities have opened a total of 102 dialysis stations within the designated planning area for chronic dialysis (HFPA's 413, 415 and 417) since Herrick opened its unit.

- Alta Bates received approval in 1980 from the HSA and State to expand the size of its unit by 10 stations.

- The Alameda/Contra Costa Health Systems Plan projects a need by 1982 for additional stations in all dialysis planning areas in HSA 5.

THE COST OF DIALYSIS SERVICES AT ALTA BATES IS SIGNIFICANTLY LOWER THAN AT HERRICK.

Alta Bates maintains the license for its dialysis program and contracts with an independent professional corporation, Community Hemodialysis, Inc. (CHU) for medical direction of the program. As a for-profit corporation, CHU is subject to far more rigid reimbursement standards than hospital-based units such as Herrick's.

Allegations in the CCPH that Alta Bates' dialysis unit is "profiteering" (page 17) are false. The average charge per dialysis treatment at Herrick Hospital is $311, while at Alta Bates it is $138.

B. CARDIAC CATHETERIZATION SERVICES (P. 17 OF CCPH REPORT).

The East Bay has a high number of "freestanding" (i.e., not operated in the same facility as a cardiac surgery unit) cardiac catheterization labs. Like the one in service at Alta Bates, most of these operate as part of well-utilized, multi-purpose special procedures rooms and are very cost effective.

ALTA BATES' CARDIAC CATH LAB IS WELL UTILIZED.

In 1980 approximately 160 cardiac caths and 242 angiographic procedures were performed in one well-utilized room.

ALTA BATES' CARDIAC CATH SERVICE IS COST EFFECTIVE BECAUSE OF ITS MULTIPURPOSE USE AS A SPECIAL PROCEDURES ROOM.

Bay Area Comprehensive Health Planning conducted a study in the mid-1970's of comparative costs per cardiac catheterization case as performed in three different settings: a university teaching hospital; a community hospital with a cardiac surgery program; and a community hospital with a freestanding cath lab. The study, which used Alta Bates as the case example of a freestanding cath lab, showed that costs per case were lowest in the Alta Bates' cath lab, largely because of the high utilization of its multipurpose special procedures room.

SERVICE QUALITY AT FREESTANDING CATH LABS EQUALS THAT AT HOSPITALS WITH SURGERY PROGRAMS.

There has been no substantial indication that smaller, freestanding cath labs show any significant difference in quality of service from large cath labs associated with surgery programs. Since opening its cath program in 1972, Alta Bates has experienced no deaths associated with the program and a well-below average complication rate for all patients receiving catheterization.

C. RADIATION DECONTAMINATION (P. 17 OF CCPH REPORT).

Both Alta Bates and Herrick Hospital have publicly refuted concerns expressed in the CCPH report about possible duplication of radiation decontamination rooms. These rooms at both facilities are little more than glorified, standy showers which could be used in the remote possibility of a radiation accident at Lawrence Berkeley Lab or elsewhere in the community. As its officials have stated, Herrick has no official designation for such a service. Alta Bates' service can be used in support of its Burn Center to decontaminate chemical burn patients. Neither service has any significant impact on the cost of services elsewhere in the hospitals.

7. BURN CENTER SERVICES (P. 18 OF CCPH REPORT).

Alta Bates established its six-bed burn center in 1975; it was the first burn center in the East Bay. Two other programs have been established since then at Brookside and Eden Hospitals. The current HSA plan shows a need for 13 burn beds. Currently 18 are available. However, all three facilities providing burn services report an acceptable level of utilization.

8. ALCOHOL SERVICES

Alta Bates developed the first hospital-based inpatient alcohol rehabilitation program in the East Bay. The 17-bed inpatient unit is very highly utilized, often with a waiting list. Several other hospital based or freestanding units have been developed in the East Bay since then and all are generally well-utilized.

9. HERRICK'S CON APPLICATION TO CONVERT LICENSED SKILLED NURSING BEDS INTO MEDICAL/SURGICAL BEDS.

The CCPH report indicated (p. 17) that Herrick has recently applied for HSA permission to increase bed capacity and suggested that approval of this request might result in better utilization of medical/surgical beds. The following facts should be noted:

A. HERRICK HAS FILED A CON TO CONVERT 30 LICENSED SKILLED NURSING BEDS TO MEDICAL/SURGICAL CAPACITY.

Herrick obtained approval to build a 30-bed SNF unit when it undertook a major remodeling program several years ago. It never initiated operation of this unit and now has filed to change the license category of these beds to medical/surgical. In a letter from the Administrator of Herrick, Mr. Hershel Shelton, to the Chief of the Division of Certificate of Need of OSHPD (February 11, 1981), Mr. Shelton states his belief that conversion of 30 SNF beds to medical/surgical capacity at Herrick is a less costly alternative to Alta Bates' present application to add 22 obstetrical beds to our license to accommodate the High-Risk Obstetrical Program.

B. HSA PROJECTIONS SHOW A LARGE EXCESS OF MEDICAL/SURGICAL BEDS IN THE BERKELEY HFPA.

HSA bed need projections show an excess of 204 medical/surgical beds in the Berkeley area by 1985 and an excess of almost 1800 in the Alameda-Contra Costa County HSA.

C. A GREAT NEED FOR SNF BEDS EXISTS IN ALAMEDA AND CONTRA COSTA COUNTIES.

The current Statewide Health Facilities and Services Plan indicates there is a deficit of 1,340 SNF beds in HSA 5. In 1980 alone, Alta Bates identified 1,600 acute patient days attributable to patients waiting for placement in overcrowded skilled nursing facilities.

Further, Herrick carefully documented the need for these 30 SNF beds in the applications to the Comprehensive Health Planning Agency and to state loan guarantee bodies for their 1980 building project. In these documents, they presented an effective argument that, in addition to a general community need for SNF beds, the availability of such a service at Herrick would enable them to shift patients from their medical/surgical and rehabilitation units in a manner that would result in a more cost effective service.

Alta Bates' CON application is based on a documentable need for more obstetrical beds to support an existing, regionally-utilized high-risk maternity program. The application by Herrick to convert needed SNF beds to medical/surgical beds will have to be similarly justified. The two applications should not be interlinked; each should be evaluated on its own merits.

In conclusion, we feel the above evidence supports the fact that Alta Bates has not inappropriately duplicated services at Herrick or other facilities and has not had significant adverse impact on the utilization or economic well-being of these institutions.

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